OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Winston Farrell	**3/19/1960**	**134-82-7876**
Patient Address		
1537 Long Fellow Avenue, Bronx, NY 10460		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Enrico D'Angelo, MD, 1803 Mahan Avenue, Bronx, NY 10461

8. Name and address of person(s) or category of person to whom this information will be sent:
NYC Law Department, Corporation Counsel, 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: Law Suit	6/29/2008
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

NOTARY PUBLIC
MICHAEL FINEMAN
REG. NO. 02AV6106621
COUNTY KINGS
EXP. 03/06/2008

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Winston Farrell
Signature of patient or representative authorized by law.

Date: 06/29/07

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DESIGNATION OF AGENT FOR ACCESS TO SEALED RECORDS PURSUANT TO NYCPL 160.50[1] [d]

I, Winston Farrell, Date of Birth, March 19, 1960 SS# 134-82-7876 pursuant to CPL § 160.50[l][d], hereby designate The New York City Corporation Counsel, Law Department, 100 Church Street, New York, NY 10007, or their authorized representative, as my agent to whom records of the criminal action terminated in my favor entitled People of the State of New York v .Winston Farrell, Docket No. or Indictment No. none, in Criminal Court, County of New York, State of New York, relating to my arrest on or about June 9, 2006, may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL § 160.50, which permits those records to be made available only (I) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL § 160.50.

The records to be made available to the person designated above comprise all records and papers relating to my arrest and prosecution in the criminal action identified herein on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL § 160.50.

Winston Farrell

STATE OF NEW YORK)
SS.:
COUNTY OF New York)

On this 29 day of June, 2007, before me personally came Winston Farrell, to me known and known to me to be the individual described in and who executed the foregoing instrument, and she acknowledged to me that she executed the same.

NOTARY PUBLIC

NOTARY PUBLIC
MICHAEL FINEMAN
REG. NO. 02AV6106621
COUNTY KINGS
EXP. 03/08/2008